TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Medme Services Corporation

**Respondent Name**
Service Lloyds Insurance Co

**MFDR Tracking Number**
M4-16-1807-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
February 26, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The submitted documentation supports our request for payment on the disputed fee issues."

**Amount in Dispute:** $400.56

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "A4595 (Electrical stimulator supplies, 2 lead, per month, [(e.g., TENS, NMES)] is the HCPCS code used to bill for supplies necessary for the use of the covered TENS unit. Itemized supplies are not paid separately. A4630 is the code for "medically necessary" replacement batteries. No separate payment will be made for this item when billed with A4595 as A4595 is an all-inclusive code."

**Response Submitted by:** CorVel Healthcare Corporation

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 30, 2015<br>April 30, 2015<br>May 28, 2015 | A4630 x 1 unit, A4557 x 2 units, L0625 x 1 unit<br>A4630 x 1 unit, A4557 x 2 units, L0625 x 1 unit<br>A4630 x 1 unit, A4557 x 2 units, L0625 x 1 unit | $400.56 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §134.203 sets out he reimbursement guidelines for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment adjusted for absence of precert/preauth
   - ODG – Services exceed ODG guidelines; preauth is required
   - 234 – This procedure is not paid separately
   - 50 – Services not Deemed "Medically Necessary" by payer
   - W3 – Appeal / Reconsideration

**Issues**

1. Does the medical fee dispute referenced above contain information/documentation that indicates that there are unresolved issues of medical necessity, for date of service May 28, 2015?
2. Is the insurance carrier's denial or reduction of payment supported?
3. Is the requestor entitled to reimbursement?

**Findings**

1. Review of the submitted EOB dated November 5, 2015 for date of service May 28, 2015, supports that the insurance carrier denied/reduced HCPCs Level II codes A4630, A4557, and L0625 with denial reason code "50 – Service not deemed 'Medically Necessary' by payer.

   Review of the submitted documentation finds that the medical fee dispute referenced for date of service May 28, 2015, contains information/documentation that indicates that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute.

   The respondent included the following in regards to disputed service L0625, "These services have been retrospectively reviewed." The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to Health Care Providers on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under Health Care Providers or their authorized representatives. Review of the submitted documentation finds insufficient evidence to support requirements of Rule 133.308.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

   The medical fee dispute for date of service May 28, 2015, may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

   The Division finds that due to the unresolved medical necessity issues for date of service, May 28, 2015, the medical fee dispute request is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

   The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This dismissal is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered.

   The Division finds that date of service, May 28, 2015, is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

2. The requestor seeks payment for HCPCS Level II Codes, A4630-NU and A4557-NU, rendered on, March 30, 2015 and April 30, 2015. The insurance carrier denied the disputed services with claim adjustment reason code "234 – This procedure is not paid separately.

28 Texas Administrative Code §134.203 (b), states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The AMA CPT Code Book defines HCPCS Level II Code as follows:

> A4630 – Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient.
>
> A4557 – Lead wires (e.g., apnea monitor), per pair.
>
> A4595 – Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)

The requestor appended modifier "NU- New equipment" to HCPCS Codes A4630 and A4557. The insurance carrier issued payment for HCPCS Level II code A4595 and the requestor seeks reimbursement for A4630-NU and A4557-NU.

The applicable Medicare Coding Guidelines when billing HCPCS Code A4630 is as follows:

> *"A TENS supply allowance (A4595) includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation material, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if recharger batteries were used)."*

The requestor seeks payment for A4630-NU, which is bundled into HCPCS code A4595, previously paid by the insurance carrier. As a result, reimbursement cannot be recommended for HCPCS Level II code A4630-NU rendered on March 30, 2015 and April 30, 2015.

The applicable Medicare Coding Guidelines when billing HCPCS Codes A4557 is as follows:

> *"Replacement of lead wires (A4558) more often than every 12 months would rarely be... necessary."*

The respondent states, "The TENS unit was purchased 12/3/2014…" The dates of service in dispute are March 30, 2015 and April 30, 2015 as a result, reimbursement cannot be recommended for HCPCS Level II code A4557 as these dates of service are prior to one year from the date of purchase.

For HCPCS Level II code L0625 rendered on March 30, 2015 and April 30, 2015. The carrier denied the disputed service as 197 – "Payment adjusted for absence of precert/preauth" and ODG – "Services exceed ODG guidelines; preauth is required". Review of the above information finds the service in dispute was for a lumbar support. The 2015 Official Disability Guidelines for "Lumbar supports" finds:

> *Criteria for Lumbar Supports:*
>
> *Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option).*

Based on the review of the submitted documentation the diagnosis is 847.2 – "Lumbar sprain and strain". As this condition is not listed as recommended for treatment with a lumbar support, the carrier's denial is supported.

3. 28 Texas Administrative Code §137.100 (d) states,

> The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless:
>
> (1) the treatment(s) or service(s) were provided in a medical emergency; or
>
> (2) the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.300 of this title.

The Division finds insufficient information to support the above mentioned requirements were met. Therefore, no additional reimbursement can be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | March , 2016 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.